**Amendment No. 402**

| Senate Amendment to Senate Bill No. 393 (BDR 57-101) |
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| **Proposed by:** Senate Committee on Commerce and Labor |
| **Amends:** Summary: No Title: Yes Preamble: No Joint Sponsorship: No Digest: Yes |

| ASSEMBLY ACTION | | Initial and Date | SENATE ACTION | | Initial and Date |
|---|---|---|---|---|---|
| Adopted ☐ | Lost ☐ | | Adopted ☐ | Lost ☐ | |
| Concurred In ☐ | Not ☐ | | Concurred In ☐ | Not ☐ | |
| Receded ☐ | Not ☐ | | Receded ☐ | Not ☐ | |

EXPLANATION: Matter in (1) ***blue bold italics*** is new language in the original bill; (2) variations of **green bold underlining** is language proposed to be added in this amendment; (3) ~~red strikethrough~~ is deleted language in the original bill; (4) ~~purple double strikethrough~~ is language proposed to be deleted in this amendment; (5) orange double underlining is deleted language in the original bill proposed to be retained in this amendment.

DP/EWR Date: 4/23/2023

S.B. No. 393—Revises provisions related to dental insurance. (BDR 57-101)

SENATE BILL NO. 393–SENATOR SEEVERS GANSERT

MARCH 27, 2023

Referred to Committee on Commerce and Labor

SUMMARY—Revises provisions related to dental insurance. (BDR 57-101)

FISCAL NOTE: Effect on Local Government: May have Fiscal Impact.
Effect on the State: Yes.

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EXPLANATION – Matter in ***bolded italics*** is new; matter between brackets [~~omitted material~~] is material to be omitted.

AN ACT relating to insurance; [~~making certain provisions governing insurance rates applicable to contracts providing coverage for dental care sold to small employers;~~] revising the circumstances under which a rate paid for dental coverage is presumed to be excessive; establishing certain procedures to enforce the prohibition on imposing excessive rates for dental coverage; [~~prescribing a time period within which a dental insurer is required to retain certain documents; imposing certain requirements related to billing, diagnostic and procedure codes submitted to an insurer by dentists and dental hygienists;~~] and providing other matters properly relating thereto.

**Legislative Counsel's Digest:**

Existing law prohibits the sale or offering for sale of any contract providing coverage for dental care at a rate which is excessive, defined as a ratio of losses to premiums collected which is less than 75 percent. Existing law exempts contracts providing coverage for dental care that are sold to small employers from this prohibition. (NRS 686B.125) **Section 3** of this bill [~~: (1) eliminates the exemption of contracts providing coverage for dental care that are sold to small employers; and (2) revises the method for calculating the ratio of losses to premiums collected which is presumed to be excessive for contracts providing coverage for dental care in this State.~~] **requires an insurer, organization or person licensed to engage in the business of insurance in this State that provides coverage for dental care in this State to report certain information concerning the losses and premiums collected by the insurer, organization or person.** **Section 3** authorizes the Commissioner of Insurance to examine the records and transactions of those insurers, organizations and [~~other~~] persons to ascertain compliance with the prohibition on selling or offering for sale any contract providing coverage for dental care at an excessive rate [~~. If, after conducting such an examination,~~] **and the reporting requirement. Beginning in 2026, if** the Commissioner determines that an insurer, organization or [~~other~~] person has violated [~~that~~] **the** prohibition [~~,~~] **on charging excessive rates, section** [~~3.~~] **3.5 of this bill:** (1) requires the insurer, organization or [~~other~~] person to submit an adjusted rate filing; and (2) authorizes the Commissioner to require the insurer, organization or [~~other~~] person to submit a plan to compensate insureds or members who were affected by excessive rates. [~~Finally, section 3 requires insurers, organizations and other persons to maintain certain records relating to underwriting and sales of contracts providing for dental care for not less than 5 years after the end of the calendar year in which the records were created. Section 2 of this bill requires the Commissioner to disapprove a rate filing that includes a proposed rate that is excessive pursuant to section 3.~~]

~~Sections 4 and 7 of this bill prohibit a health carrier which provides dental coverage, an administrator of a health benefit plan that provides dental coverage, an organization for dental care or an administrator for an organization for dental care from altering a billing code or other coding relating to diagnostics and procedures submitted by a dentist or dental hygienist for billing purposes: (1) in a manner that prevents a dentist or dental hygienist from collecting the contracted fee for actual services performed; or (2) with the intent to reduce or deny reimbursement otherwise due to the dentist or dental hygienist, with certain exceptions. Sections 4 and 7 also prohibit such a health carrier, organization for dental care or administrator from using code bundling in a manner such that a code is rendered unbillable to an insured unless the code is for a procedure that may be performed in conjunction with another procedure. Sections 4 and 7 require such a health carrier, organization for dental care or administrator that alters a code to provide certain information concerning the alteration to the insured in an explanation of benefits. Sections 4 and 7 prohibit such a health carrier, organization for dental care or administrator from stating in an explanation of benefits that a code submitted by a dentist was inappropriate or a charge was excessive without clear evidence. Finally, sections 4 and 7 require such a health carrier, organization for dental care or administrator to disclose its policies concerning downcoding and code bundling to each dentist or dental hygienist with which the health carrier, organization for dental care or administrator has contract for the provision of services. Sections 8-10 of this bill make the provisions of section 4 applicable to coverage for dental benefits provided by employers, including the State and local governments. Sections 5 and 6 of this bill make conforming changes to indicate the proper placement of section 4 in the Nevada Revised Statutes.~~

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THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

**Section 1.** ~~[NRS 686B.030 is hereby amended to read as follows:~~

~~686B.030 1. Except as otherwise provided in subsection 2 , [and NRS 686B.125,] the provisions of NRS 686B.010 to 686B.1799, inclusive, apply to all kinds and lines of direct insurance written on risks or operations in this State by any insurer authorized to do business in this State, except:~~

~~(a) Ocean marine insurance;~~

~~(b) Contracts issued by fraternal benefit societies;~~

~~(c) Life insurance and credit life insurance;~~

~~(d) Variable and fixed annuities;~~

~~(e) Credit accident and health insurance;~~

~~(f) Property insurance for business and commercial risks;~~

~~(g) Casualty insurance for business and commercial risks other than insurance covering the liability of a practitioner licensed pursuant to chapters 630 to 640, inclusive, of NRS or who holds a license or limited license issued pursuant to chapter 653 of NRS;~~

~~(h) Surety insurance;~~

~~(i) Health insurance offered through a group health plan maintained by a large employer; and~~

~~(j) Credit involuntary unemployment insurance.~~

~~2. The exclusions set forth in paragraphs (f) and (g) of subsection 1 extend only to issues related to the determination or approval of premium rates.]~~ **(Deleted by amendment.)**

**Sec. 2.** ~~[NRS 686B.112 is hereby amended to read as follows:~~

~~686B.112 1. The Commissioner shall perform an actuarial review of and consider each rate filing of a health plan issued pursuant to the provisions of chapter 689A, 689B, 689C, 695B, 695C, 695D or 695F of NRS, including, without limitation, long-term care and Medicare supplement plans, filed with the~~

~~Commissioner pursuant to subsection 1 of NRS 686B.070. If the Commissioner finds that a proposed rate which is contained in a rate filing will result in a rate which is not in compliance with NRS 686B.050 , [or] subsection 3 of NRS 686B.070 [,] *or subsection 1 of NRS 686B.125,* the Commissioner shall disapprove the rate filing. The Commissioner shall approve or disapprove each rate filing not later than 60 days after the rate filing is determined by the Commissioner to be complete pursuant to subsection 4. If the Commissioner fails to approve or disapprove the rate filing within that period, the rate filing shall be deemed approved.~~

~~2. Whenever an insurer has no legally effective rates as a result of the Commissioner's disapproval of rates or other act, the Commissioner shall on request specify interim rates for the insurer that are high enough to protect the interests of all parties and may order that a specified portion of the premiums be placed in an escrow account approved by the Commissioner. When new rates become legally effective, the Commissioner shall order the escrowed funds or any overcharge in the interim rates to be distributed appropriately, except that refunds to policyholders that are de minimis must not be required.~~

~~3. If the Commissioner disapproves a rate filing pursuant to subsection 1, and an insurer requests a hearing to determine the validity of the action of the Commissioner, the insurer has the burden of showing compliance with the applicable standards for rates established in NRS 686B.010 to 686B.1799, inclusive. Any such hearing must be held:~~

~~(a) Within 30 days after the request for a hearing has been submitted to the Commissioner; or~~

~~(b) Within a period agreed upon by the insurer and the Commissioner.~~

~~→ If the hearing is not held within the period specified in paragraph (a) or (b), or if the Commissioner fails to issue an order concerning the rate filing for which the hearing is held within 45 days after the hearing, the rate filing shall be deemed approved.~~

~~4. The Commissioner shall by regulation specify the documents or any other information which must be included in a rate filing submitted to the Commissioner pursuant to subsection 1. Each such rate filing shall be deemed complete upon its filing with the Commissioner, unless the Commissioner, within 15 business days after the rate filing is filed with the Commissioner, determines that the rate filing is incomplete because the rate filing does not comply with the regulations adopted by the Commissioner pursuant to this subsection.~~

~~5. The Commissioner may assess against an insurer the actual cost for the external actuarial review of a rate filing submitted pursuant to subsection 1.]~~

**(Deleted by amendment.)**

**Sec. 3.** NRS 686B.125 is hereby amended to read as follows:

686B.125 1. Except as otherwise provided in this section, no ~~*[An]*~~ insurer, organization or ~~*[other]*~~ person licensed pursuant to this title may ~~*[shall not]*~~ sell or offer to sell any contract providing coverage for dental care ~~*[in this State]*~~ at a rate which is excessive for the benefits offered to the insured or member. For the purpose of this section , a ~~*[:*~~

~~*(a) For the first or second calendar year or part of a calendar year that an insurer, organization or other person sells or offers to sell in this State a contract providing coverage for dental care, an aggregate average]*~~ ratio of losses to premiums collected ~~*[over the entire period that the insurer, organization or other person has sold or offered to sell such contracts in this State]*~~ which is less than 75 percent is presumed to show an excessive rate.

~~*[(b) For each calendar year thereafter, an aggregate average ratio of losses to premiums collected over any 3 year period that is more than 1.5 standard*~~

~~deviations below the aggregate average ratio of losses to premiums collected for all insurers, organizations and other persons that sell or offer to sell contracts providing coverage for dental care in this State over the same 3-year period, as calculated by the Commissioner pursuant to paragraph (a) of subsection 4, is presumed to show an excessive rate.]~~

2. The provisions of subsection 1 do not apply to a contract providing coverage for dental care that is sold to a small employer pursuant to the provisions of chapter 689C of NRS.

~~[ 3. ]~~ As used in this ~~[section,]~~ ***subsection,*** "small employer" has the meaning ascribed to it in NRS 689C.095.

***3. Each year, every insurer, organization or ~~[other]~~ person licensed pursuant to this title who ~~[sells or offers to sell in this State any contract providing]~~ provides coverage for dental care in this State shall, in accordance with requirements established by regulation of the Commissioner, file with the Commissioner a report of the losses and premiums collected for that insurer, organization or person, as applicable, for ~~[:~~***

~~(a) Each of the immediately preceding 3 calendar years, if the insurer, organization or other person has sold or offered to sell contracts providing coverage for dental care in this State for more than 2 calendar years.~~

~~(b) Each]~~ ***the calendar year . ~~[that the insurer, organization or other person has sold or offered to sell such contracts in this State, if the insurer, organization or other person has sold or offered to sell contracts providing coverage for dental care in this State for 2 calendar years or fewer.~~***

~~3.]~~ ***4. For the purposes of subsection ~~[2,]~~ 3, the values of losses and premiums collected must be determined at the end of each calendar year for the entire calendar year.***

~~[4. The Commissioner shall, based on the reports filed pursuant to subsection 2:~~

~~(a) Calculate, for the immediately preceding 3-year period, the aggregate average ratio of losses to premiums collected for all insurers, organizations and other persons who sold or offered to sell contracts providing coverage for dental care in this State;~~

~~(b) Calculate the aggregate average ratio of losses to premiums collected for each such insurer, organization and other person for the immediately preceding 3-year period or for the entire period during which the insurer, organization or other person has sold or offered to sell contracts providing dental care in this State, whichever time period is shorter; and~~

~~(c) Identify each such insurer, organization and other person whose aggregate average ratio of losses to premiums collected is presumed to show an excessive rate pursuant to subsection 1.~~

~~5. On April 1 of each year, the Commissioner shall publish on an internet website maintained by the Division:~~

~~(a) A list of each insurer, organization or other person who provided coverage for dental care in this State during the immediately preceding calendar year; and~~

~~(b) For each such insurer, organization or other person, the aggregate average ratio of losses to premiums collected for the immediately preceding 3-year period or for the entire period during which the insurer, organization or other person has sold or offered to sell contracts providing dental care in this State, whichever time period is shorter.~~

~~6.]~~ ***5. The Commissioner may, pursuant to NRS 679B.240, examine the accounts, records, documents and transactions of any insurer, organization or ~~[other]~~ person licensed pursuant to this title who sells or offers to sell any***

***contract providing coverage for dental care in this State to ascertain compliance with the provisions of this section.***

~~***[7. If the Commissioner determines, after conducting an examination pursuant to subsection 6, that an insurer, organization or other person has failed to comply with the provisions of subsection 1:***~~

~~***(a) The insurer, organization or other person, as applicable, must submit to the Commissioner an adjusted rate filing in accordance with NRS 686B.070 not later than 60 days after the date of the determination, regardless of whether the insurer, organization or other person is requesting a change in rates. If the Commissioner determines, based on the historical loss experience of the insurer, organization or other person, that the previously approved rates are excessive, the Commissioner may require the insurer, organization or other person to file a decreased rate that would bring the insurer, organization or other person into compliance with provisions of subsection 1.***~~

~~***(b) The Commissioner may order the insurer, organization or other person to submit a plan to compensate any insureds or members who:***~~

~~***(1) Are residents of this State; and***~~

~~***(2) Were affected by the excessive rates during any year under examination pursuant to subsection 6.***~~

~~***8. An insurer, organization or other person shall maintain records relating to the underwriting and sales of contracts providing coverage for dental care in this State for not less than 5 years after the end of the calendar year in which such a record was created.]***~~

***Sec. 3.5.*** **NRS 686B.125 is hereby amended to read as follows:**

686B.125 1. Except as otherwise provided in this section, no insurer, organization or person licensed pursuant to this title may sell or offer to sell any contract providing coverage for dental care at a rate which is excessive for the benefits offered to the insured or member. For the purpose of this section, a ratio of losses to premiums collected which is less than 75 percent is presumed to show an excessive rate.

2. ~~[The provisions of subsection 1 do not apply to a contract providing coverage for dental care that is sold to a small employer pursuant to the provisions of chapter 689C of NRS. As used in this subsection "small employer" has the meaning ascribed to it in NRS 689C.095.~~

~~3.]~~ Each year, every insurer, organization or person licensed pursuant to this title who provides coverage for dental care in this State shall, in accordance with requirements established by regulation of the Commissioner, file with the Commissioner a report of the losses and premiums collected for that insurer, organization or person, as applicable, for the calendar year.

~~[4.]~~ ***3.*** For the purposes of subsection ~~[3,]~~ ***2,*** the values of losses and premiums collected must be determined at the end of each calendar year for the entire calendar year.

~~[5.]~~ ***4. The Commissioner shall, based on the reports filed pursuant to subsection 2:***

***(a) Calculate the aggregate average ratio of losses to premiums collected for each such insurer, organization and other person licensed pursuant to this title for the immediately preceding 3-year period or for the entire period during which the insurer, organization or other person has provided coverage for dental care in this State, whichever time period is shorter, for each market segment in which the insurer, organization or person operates; and***

***(b) Identify each such insurer, organization and other person licensed pursuant to this title whose aggregate average ratio of losses to premiums***

***collected for a market segment is presumed to show an excessive rate pursuant to subsection 1.***

***5. On or before June 1 of each year, the Commissioner shall publish on an internet website maintained by the Division:***

***(a) A list of each insurer, organization or person licensed pursuant to this title who provided coverage for dental care in this State during the immediately preceding calendar year; and***

***(b) For each such insurer, organization or person licensed pursuant to this title, the aggregate average ratio of losses to premiums collected for the immediately preceding 3-year period or for the entire period during which the insurer, organization or person has provided coverage for dental care in this State, whichever time period is shorter, for each market segment in which the insurer, organization or person operates.***

***6.*** The Commissioner may, pursuant to NRS 679B.240, examine the accounts, records, documents and transactions of any insurer, organization or person licensed pursuant to this title who sells or offers to sell any contract providing coverage for dental care in this State to ascertain compliance with the provisions of this section.

***7. If the Commissioner determines, after conducting an examination pursuant to subsection 6, that an insurer, organization or person licensed pursuant to this title has failed to comply with the provisions of subsection 1:***

***(a) The insurer, organization or person, as applicable, must submit to the Commissioner an adjusted rate filing in accordance with NRS 686B.070 not later than 60 days after the date of the determination, regardless of whether the insurer, organization or person is requesting a change in rates. If the Commissioner determines, based on the information calculated pursuant to paragraph (a) of subsection 4, that the previously approved rates are excessive, the Commissioner may require the insurer, organization or person to file a decreased rate that would bring the insurer, organization or person into compliance with provisions of subsection 1.***

***(b) The Commissioner may order the insurer, organization or person to submit a plan to compensate any insureds or members who:***

***(1) Are residents of this State; and***

***(2) Were affected by the excessive rates during any year under examination pursuant to subsection 6.***

***8. The provisions of subsections 1 and 7 and paragraph (b) of subsection 4 do not apply to a contract providing coverage for dental care that is sold to a small employer pursuant to the provisions of chapter 689C of NRS. As used in this subsection, "small employer" has the meaning ascribed to it in NRS 689C.095.***

**Sec. 4.** ~~[Chapter 687B of NRS is hereby amended by adding thereto a new section to read as follows:~~

~~*1. A health carrier which provides dental coverage or an administrator of a health benefit plan that includes dental coverage shall not:*~~

~~*(a) Alter a code in a manner that prevents a dentist from collecting from the insured or health carrier the contracted fee for actual services performed.*~~

~~*(b) Alter a code with the intent to reduce or deny reimbursement otherwise due to a dentist unless:*~~

~~*(1) The alteration is consistent with the policies of the health carrier or administrator, as applicable;*~~

~~*(2) The health carrier or administrator, as applicable, possesses sufficient information and clinical evidence to make the alteration; and*~~

~~*(3) The health carrier or administrator, as applicable, consults with the dentist before making the alteration.*~~

~~*(c) Use code bundling in a manner such that a code is rendered unbillable to an insured unless, under generally accepted standards of practice, the code is for a procedure that may be performed in conjunction with another procedure.*~~

~~*2. If a health carrier or administrator alters a code, the health carrier or administrator, as applicable, shall state on the explanation of benefits that is provided to the insured:*~~

~~*(a) The clinical reason for altering the code; and*~~

~~*(b) A citation to the applicable policy of the health carrier or administrator, as applicable.*~~

~~*3. A health carrier or administrator shall not, in an explanation of benefits, state or infer that:*~~

~~*(a) A code submitted by a dentist was inappropriate unless the health carrier or administrator, as applicable, possesses clear evidence that the code listed on the claim for reimbursement by the dentist is in no way related to the procedure actually performed by the dentist.*~~

~~*(b) A charge by a dentist was excessive unless the health carrier or administrator, as applicable, possesses clear evidence that the charge was substantially greater than the regular fees of the dentist.*~~

~~*4. A health carrier or administrator shall disclose the specific policies of the health carrier or administrator concerning downcoding and code bundling to each dentist with whom the health carrier contracted for the provision of services:*~~

~~*(a) Through mail or electronic mail; or*~~

~~*(b) On an Internet website maintained by the health carrier or administrator, as applicable.*~~

~~*5. As used in this section:*~~

~~*(a) "Code" means:*~~

~~*(1) A billing code; or*~~

~~*(2) Any other coding relating to diagnostics and procedures.*~~

~~*(b) "Code bundling" means combining distinct dental procedures into a single procedure and code for billing purposes.*~~

~~*(c) "Dentist" has the meaning ascribed to it in NRS 695D.040.*~~

~~*(d) "Downcoding" means the alteration by a health carrier or administrator of a code submitted with a claim for reimbursement by a dentist to a code for a procedure of lesser complexity, resulting in a decrease in reimbursement to the dentist.]~~ (Deleted by amendment.)**

**Sec. 5.** ~~[NRS 687B.600 is hereby amended to read as follows:~~

~~687B.600 As used in NRS 687B.600 to 687B.850, inclusive, *and section 4 of this act,* unless the context otherwise requires, the words and terms defined in NRS 687B.602 to 687B.665, inclusive, have the meanings ascribed to them in those sections.~~**]** (Deleted by amendment.)**

**Sec. 6.** ~~[NRS 687B.670 is hereby amended to read as follows:~~

~~687B.670 If a health carrier offers or issues a network plan, the health carrier shall, with regard to that network plan:~~

~~1. Comply with all applicable requirements set forth in NRS 687B.600 to 687B.850, inclusive~~ **[;] *, and section 4 of this act;***

~~2. As applicable, ensure that each contract entered into for the purposes of the network plan between a participating provider of health care and the health carrier complies with the requirements set forth in NRS 687B.600 to 687B.850, inclusive~~ **[;] *, and section 4 of this act;*** ~~and~~

~~3. As applicable, ensure that the network plan complies with the requirements set forth in NRS 687B.600 to 687B.850, inclusive~~ **[.] *, and section 4 of this act.]*** **(Deleted by amendment.)**

**Sec. 7.** ~~[Chapter 695D of NRS is hereby amended by adding thereto a new section to read as follows:~~

~~*1. An organization for dental care or an administrator shall not:*~~

~~*(a) Alter a code in a manner that prevents a dentist from collecting from the member or organization for dental care the contracted fee for actual services performed.*~~

~~*(b) Alter a code with the intent to reduce or deny reimbursement otherwise due to a dentist unless:*~~

~~*(1) The alteration is consistent with the policies of the organization for dental care or administrator, as applicable;*~~

~~*(2) The organization for dental care or administrator, as applicable, possesses sufficient information and clinical evidence to make the alteration; and*~~

~~*(3) The organization for dental care or administrator, as applicable, consults with the dentist before making the alteration.*~~

~~*(c) Use code bundling in a manner such that a code is rendered unbillable to a member unless, under generally accepted standards of practice, the code is for a procedure that may be performed in conjunction with another procedure.*~~

~~*2. If an organization for dental care or administrator alters a code, the organization for dental care or administrator, as applicable, shall state on the explanation of benefits that is provided to the member:*~~

~~*(a) The clinical reason for altering the code; and*~~

~~*(b) A citation to the applicable policy of the organization for dental care or administrator, as applicable.*~~

~~*3. An organization for dental care or administrator shall not, in an explanation of benefits, state or infer that:*~~

~~*(a) A code submitted by a dentist was inappropriate unless the organization for dental care or administrator, as applicable, possesses clear evidence that the code listed on the claim for reimbursement by the dentist is in no way related to the procedure actually performed by the dentist.*~~

~~*(b) A charge by a dentist was excessive unless the organization for dental care or administrator, as applicable, possesses clear evidence that the charge was substantially greater than the regular fees of the dentist.*~~

~~*4. An organization for dental care or administrator shall disclose the specific policies of the organization for dental care or administrator concerning downcoding and code bundling to each dentist with whom the organization for dental care contracted for the provision of services:*~~

~~*(a) Through mail or electronic mail; or*~~

~~*(b) On an Internet website maintained by the organization for dental care or administrator, as applicable.*~~

~~*5. As used in this section:*~~

~~*(a) "Code" means:*~~

~~*(1) A billing code; or*~~

~~*(2) Any other coding relating to diagnostics and procedures.*~~

~~*(b) "Code bundling" means combining distinct dental procedures into a single procedure and code for billing purposes.*~~

~~*(c) "Downcoding" means the alteration by an organization for dental care or administrator of a code submitted with a claim for reimbursement by a dentist to a code for a procedure of lesser complexity, resulting in a decrease in reimbursement to the dentist.]~~ **(Deleted by amendment.)**

**Sec. 8.** ~~[NRS 287.010 is hereby amended to read as follows:~~

~~287.010 1. The governing body of any county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada may:~~

~~(a) Adopt and carry into effect a system of group life, accident or health insurance, or any combination thereof, for the benefit of its officers and employees, and the dependents of officers and employees who elect to accept the insurance and who, where necessary, have authorized the governing body to make deductions from their compensation for the payment of premiums on the insurance.~~

~~(b) Purchase group policies of life, accident or health insurance, or any combination thereof, for the benefit of such officers and employees, and the dependents of such officers and employees, as have authorized the purchase, from insurance companies authorized to transact the business of such insurance in the State of Nevada, and, where necessary, deduct from the compensation of officers and employees the premiums upon insurance and pay the deductions upon the premiums.~~

~~(c) Provide group life, accident or health coverage through a self-insurance reserve fund and, where necessary, deduct contributions to the maintenance of the fund from the compensation of officers and employees and pay the deductions into the fund. The money accumulated for this purpose through deductions from the compensation of officers and employees and contributions of the governing body must be maintained as an internal service fund as defined by NRS 354.543. The money must be deposited in a state or national bank or credit union authorized to transact business in the State of Nevada. Any independent administrator of a fund created under this section is subject to the licensing requirements of chapter 683A of NRS, and must be a resident of this State. Any contract with an independent administrator must be approved by the Commissioner of Insurance as to the reasonableness of administrative charges in relation to contributions collected and benefits provided. The provisions of NRS 686A.135, 687B.352, 687B.408, 687B.723, 687B.725, 689B.030 to 689B.050, inclusive, 689B.265, 689B.287 and 689B.500 ***and section 4 of this act,*** apply to coverage provided pursuant to this paragraph, except that the provisions of NRS 689B.0378, 689B.03785 and 689B.500 only apply to coverage for active officers and employees of the governing body, or the dependents of such officers and employees.~~

~~(d) Defray part or all of the cost of maintenance of a self-insurance fund or of the premiums upon insurance. The money for contributions must be budgeted for in accordance with the laws governing the county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada.~~

~~2. If a school district offers group insurance to its officers and employees pursuant to this section, members of the board of trustees of the school district must not be excluded from participating in the group insurance. If the amount of the deductions from compensation required to pay for the group insurance exceeds the compensation to which a trustee is entitled, the difference must be paid by the trustee.~~

~~3. In any county in which a legal services organization exists, the governing body of the county, or of any school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada in the county, may enter into a contract with the legal services organization pursuant to which the officers and employees of the legal services organization, and the dependents of those officers and employees, are eligible for any life, accident or health insurance provided pursuant to this section to the officers and employees, and the dependents of the officers and employees, of the county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency.~~

~~4. If a contract is entered into pursuant to subsection 3, the officers and employees of the legal services organization:~~

~~(a) Shall be deemed, solely for the purposes of this section, to be officers and employees of the county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency with which the legal services organization has contracted; and~~

~~(b) Must be required by the contract to pay the premiums or contributions for all insurance which they elect to accept or of which they authorize the purchase.~~

~~5. A contract that is entered into pursuant to subsection 3:~~

~~(a) Must be submitted to the Commissioner of Insurance for approval not less than 30 days before the date on which the contract is to become effective.~~

~~(b) Does not become effective unless approved by the Commissioner.~~

~~(c) Shall be deemed to be approved if not disapproved by the Commissioner within 30 days after its submission.~~

~~6. As used in this section, "legal services organization" means an organization that operates a program for legal aid and receives money pursuant to NRS 19.031.]~~ **(Deleted by amendment.)**

**Sec. 9.** ~~[NRS 287.04335 is hereby amended to read as follows:~~

~~287.04335 If the Board provides health insurance through a plan of self-insurance, it shall comply with the provisions of NRS 686A.135, 687B.352, 687B.409, 687B.723, 687B.725, 689B.0353, 689B.255, 695C.1723, 695C.150, 695C.155, 695C.160, 695C.162, 695C.1635, 695C.164, 695C.1645, 695C.1665, 695C.167, 695C.1675, 695C.170 to 695C.174, inclusive, 695C.176, 695C.177, 695C.200 to 695C.230, inclusive, 695C.241 to 695C.310, inclusive, and 695C.405,~~ ~~*and section 4 of this act,*~~ ~~in the same manner as an insurer that is licensed pursuant to title 57 of NRS is required to comply with those provisions.]~~ **(Deleted by amendment.)**

**Sec. 10.** ~~[NRS 608.1555 is hereby amended to read as follows:~~

~~608.1555 Any employer who provides benefits for health care to his or her employees shall provide the same benefits and pay providers of health care in the same manner as a policy of insurance pursuant to chapters 689A and 689B of NRS, including, without limitation, as required by NRS 687B.409, 687B.723 and 687B.725~~ ~~**[.]** *and section 4 of this act.]*~~ **(Deleted by amendment.)**

**Sec. 11.** ~~[1. The amendatory provisions of sections 4 and 7 to 10, inclusive, of this act apply to any dental care provided pursuant to a contract between a health carrier or an organization for dental care and a dentist entered into on or after January 1, 2024.~~

~~2. As used in this section:~~

~~(a) "Dental care" has the meaning ascribed to it in NRS 695D.030.~~

~~(b) "Dentist" has the meaning ascribed to it in NRS 695D.040.~~

~~(c) "Health carrier" has the meaning ascribed to it in NRS 687B.625.~~

~~(d) "Organization for dental care" has the meaning ascribed to it in NRS 695D.060.]~~ **(Deleted by amendment.)**

**Sec. 12.** ~~[NRS 695D.240 is hereby repealed.]~~ **(Deleted by amendment.)**

**Sec. 13.** **1.** This **section and sections 1 to 3, inclusive, and 4 to 12, inclusive, of this** act ~~[becomes]~~ **become** effective on January 1, 2024.

**2. Section 3.5 of this act becomes effective on January 1, 2026.**

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~~TEXT OF REPEALED SECTION~~

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~~695D.240 Limitation on use of charges or premiums for marketing and administrative expenses; regulations.~~

~~1. The organization for dental care shall use not more than 25 percent of its prepaid charges or premiums for marketing and administrative expenses, including all costs to solicit members or dentists.~~

~~2. The Commissioner may adopt regulations which define "marketing and administrative expenses" for the purposes of subsection 1.~~]